

PATIENT HISTORY TRANSACTION

DO NOT SUBMIT CHANGES OR CLOSURES
ON THIS PORTION OF FORM

REPORT OF CASE OPENED

| | | | | | |
|---|-------------------|---|--|-------|--------------------------------|
| Trans. code | State file number | Patient name | Last | First | M.I. |
| Birth date (month/day/year) | | Sex | Race | | |
| | | 1—Male 2—Female 3—Unknown | 1—White 3—Spanish surname 5—American Indian 7—Other Nonwhite 2—Black 4—Asian 6—Filipino 8—No response 9—Unknown | | |
| Reporting county | | Residence county (if different than reporting county) | | | |
| | | | | | |
| Birth place—county or state or other country | | Mother's maiden name | | | |
| | | | | | |
| Presumptive CCS | | | | | |
| Eligible Dx | | | | | |
| | | | | | |
| Referral source | | | | | Referral date (month/day/year) |
| 1—Parent 4—Other provider 7—School 2—Hospital 5—CHDP/EPSTDT 8—DD regional center 3—Physician 6—CCS case finding 9—Other | | | | | |
| Disposition of case | | | | | Completed by / date |
| 1—Diagnosis only 3—Diagnosis and waiting list 2—Diagnosis and treatment 4—Therapy only | | | | | |

FILE COPY

Changes or closures are to be made on a photocopy of this transaction!
DO NOT enter changes or closures on the original copy of this transaction!

☐ **Notice of Change of Information**
(Enter only information to be changed.)
☐ **Reopen case**

Patient name 1. _____ (last)
 2. _____ (first)
 3. _____ (m.i.)

Birth date 4. _____ (month/day/year)

Sex 5. _____ 1—Male 2—Female 3—Unknown

Race 6. _____ 1—White 4—Asian 7—Other Nonwhite
 2—Black 5—American Indian 8—No response
 3—Hispanic 6—Filipino 9—Unknown

Reporting county 7. _____

Residence county 8. _____

Birth place 9. _____ (county, state, or other country)

Mother's maiden name 10. _____
 (last name only)

Presumptive Dx 11. a. _____ b. _____
 c. _____ d. _____

Referral source 12. _____ 1—Parent 4—Other provider 7—School
 2—Hospital 5—CHDP/EPSTDT 8—Regional center
 3—Physician 6—CCS case finding 9—Other

Referral date 13. _____
 Month Day Year

☐ **Report of Case Closure**

_____ (enter code here)

Reasons for case closure (use one only)

- 01—Treatment completed
 02—Eligible condition cured
 03—No treatment indicated at this time
 04—Patient reached 21 years of age
 05—Residence established in another county
 06—Residence established in another state
 07—No response at last known address
 08—Medically ineligible
 09—Financially ineligible
 10—Parents will handle privately
 11—Referred to another treatment source
 12—Death of patient
 13—Family covered by prepaid health plan
 14—Unable to keep appointments
 19—Other (specify) _____

 Effective date of closure _____
 month day year

County _____

Source of information _____

Completed by _____

Date _____

PRIVACY NOTIFICATION

This information is requested by the California Children's Services Program of the State Department of Health Services, under Section 123800 et seq. of the California Health and Safety Code, in order to provide medical treatment services. Completion of the form is required and services may be denied when not providing the information. Information will be provided to the State Department of Health Services and the county in which you reside. For more information or access to your records, contact Children's Medical Services, Program Support Section, P.O. Box 942732, Sacramento, CA 94234-7320; telephone (916) 327-1400.

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